

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN9502	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/03/2011
NAME OF PROVIDER OR SUPPLIER LEBANON HEALTH AND REHABILITATION CE		STREET ADDRESS, CITY, STATE, ZIP CODE 731 CASTLE HEIGHTS COURT LEBANON, TN 37087		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments During complaint investigation for C/O #27877, #28165, #27007, and #27036, conducted on July 25 - 29, 2011, and August 1 - 3, 2011, at Lebanon Health and Rehabilitation Center, no deficiencies were cited in relation to the complaints under, 1200-8-6, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Monia N. McElroy, NHA 8/18/11

(X6) DATE

STATE FORM

6899

V1YW11

If continuation sheet 1 of 1

AUG 22 2011